		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044768

Facility Name: MARYHAVEN NSG & REHABILITATION

Address: 1700 EAST LAKE AVE. (Number) GLENVIEW (City) 60025 (Zip Code)

County: COOK

Telephone Number: (847) 729-1300 **Fax #** (847) 729-9620

IDPA ID Number: 237061646010

Date of Initial License for Current Owners: 3/1/2000

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rose Vitacco **Telephone Number:** 773-774-8000x9903

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2002 to June 30, 2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) N/A
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	42	Skilled (SNF)	42	15,330	1
2		Skilled Pediatric (SNF/PED)			2
3	93	Intermediate (ICF)	93	33,945	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	135	TOTALS	135	49,275	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,841	7,024	1,891	14,756	8
9	SNF/PED					9
10	ICF	14,091	13,960		28,051	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,932	20,984	1,891	42,807	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.87%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
MEALS ON WHEELS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/1/00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,891

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31 Fiscal Year: 06/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	461,890	24,200		486,090		486,090		486,090			1
2	Food Purchase		238,432		238,432		238,432	(22,570)	215,862			2
3	Housekeeping		68,869		68,869		68,869		68,869			3
4	Laundry	126,465	8,894		135,359		135,359		135,359			4
5	Heat and Other Utilities			179,991	179,991		179,991		179,991			5
6	Maintenance	238,198	116,737		354,935		354,935	2,107	357,042			6
7	Other (specify):*											7
8	**TOTAL General Services**	826,553	457,132	179,991	1,463,676		1,463,676	(20,463)	1,443,213			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,914,749	42,437	7,236	1,964,422		1,964,422	2,643	1,967,065			10
10a	Therapy	56,537	10,350		66,887		66,887		66,887			10a
11	Activities	135,774			135,774		135,774		135,774			11
12	Social Services	76,574			76,574		76,574		76,574			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Spirtual Services	35,781			35,781		35,781		35,781			15
16	**TOTAL Health Care and Programs**	2,219,415	52,787	7,236	2,279,438		2,279,438	2,643	2,282,081			16
	C. General Administration											
17	Administrative	249,738		506,079	755,817		755,817	(506,079)	249,738			17
18	Directors Fees											18
19	Professional Services			7,641	7,641		7,641	160,626	168,267			19
20	Dues, Fees, Subscriptions & Promotions			13,273	13,273		13,273		13,273			20
21	Clerical & General Office Expenses		80,910		80,910		80,910	216,240	297,150			21
22	Employee Benefits & Payroll Taxes			988,352	988,352		988,352	50,070	1,038,422			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,509	2,509		2,509		2,509			24
25	Other Admin. Staff Transportation		1,649		1,649		1,649		1,649			25
26	Insurance-Prop.Liab.Malpractice			131,207	131,207		131,207		131,207			26
27	Other (specify):*											27
28	**TOTAL General Administration**	249,738	82,559	1,649,061	1,981,358		1,981,358	(79,143)	1,902,215			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,295,706	592,478	1,836,288	5,724,472		5,724,472	(96,963)	5,627,509			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION #0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			529,951	529,951		529,951	10,481	540,432			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			529,951	529,951		529,951	10,481	540,432			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	47,747	399,642	11,143	458,532		458,532		458,532			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,913	73,913		73,913		73,913			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	47,747	399,642	85,056	532,445		532,445		532,445			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,343,453	992,120	2,451,295	6,786,868		6,786,868	(86,482)	6,700,386			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: ######

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(1,525)			11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	592			14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	66,000			24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(22,570)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 42,497		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 42,497		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
MARYHAVEN NSG & REHABILITATION
ID# 0044768
Report Period Beginning: 7/1/2002
Ending: 6/30/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Tray Services	$ (19,273)		1
2	Cafeteria Vist	(1,540)		2
3	Miscellaneous	(1,757)		3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(22,570)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	2,107	0	0	0	0	0	0	0	0	0	2,107	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	2,107	0	0	0	0	0	0	0	0	0	2,107	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	2,643	0	0	0	0	0	0	0	0	0	2,643	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	2,643	0	0	0	0	0	0	0	0	0	2,643	16
	C. General Administration													
17	Administrative	0	(506,079)	0	0	0	0	0	0	0	0	0	(506,079)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	160,626	0	0	0	0	0	0	0	0	0	160,626	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	216,240	0	0	0	0	0	0	0	0	0	216,240	21
22	Employee Benefits & Payroll Taxes	0	50,070	0	0	0	0	0	0	0	0	0	50,070	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(79,143)	0	0	0	0	0	0	0	0	0	(79,143)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(74,393)	0	0	0	0	0	0	0	0	0	(74,393)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION **#** 0044768 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	10,481	0	0	0	0	0	0	0	0	0	10,481	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	10,481	0	0	0	0	0	0	0	0	0	10,481	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(63,912)	0	0	0	0	0	0	0	0	0	(63,912)	45

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Salary	$	Resurrection Health Care/Resurrection Medical Center	100.00%	$ 176,085	$ 176,085	1
2	V	22	Employee Benefit		Resurrection Health Care/Resurrection Medical Center	100.00%	50,070	50,070	2
3	V	19	Data Processing		Resurrection Health Care/Resurrection Medical Center	100.00%	137,223	137,223	3
4	V	19	Purchasing		Resurrection Health Care/Resurrection Medical Center	100.00%	23,403	23,403	4
5	V	6	Operation of Plant		Resurrection Health Care/Resurrection Medical Center	100.00%	2,107	2,107	5
6	V	10	Nursing Admin		Resurrection Health Care/Resurrection Medical Center	100.00%	2,643	2,643	6
7	V	21	Misc. A & G		Resurrection Health Care/Resurrection Medical Center	100.00%	40,155	40,155	7
8	V	30	Capital		Resurrection Health Care/Resurrection Medical Center	100.00%	10,481	10,481	8
9	V								9
10	V								10
11	V	17	INTERCOMPANY SERVICES	506,079				(506,079)	11
12	V	39	INTERCOMPANY SERVICES	399,642			399,642		12
13	V								13
14	Total			$ 905,721			$ 841,809	$ * (63,912)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MARYHAVEN NSG & REHABILITATIO # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: ######

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection HC/Medical Center
Street Address: 7435 W. Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: ((773) 774-8000
Fax Number: ((773) 594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Salary				$	$		$ 176,085	1
2	22	Employee Benefit							50,070	2
3	19	Data Processing							137,223	3
4	19	Purchasing							23,403	4
5	6	Operation of Plant							2,107	5
6	10	Nursing Admin.							2,643	6
7	21	Misc A& G							40,155	7
8	30	Capital							10,481	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 442,167	25

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION **#** 0044768 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MARYHAVEN NSG & REHABILITATION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044768

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 83,762 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		2000	$ 3,000,000	1
2					2
3	TOTALS			$ 3,000,000	3

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	134		2000	1961	$ 3,835,603	$ 196,433	35	$ 200,017	$ 3,584	$	4
5			2003		300,078	13,022		13,022		13,022	5
6											6
7											7
8											8
	Improvement Type**										
9	FACILITY			2000	7,995		20				9
10	PLUMBING			2001	7,539		20				10
11	ARCHITECT FEES			2001	3,299		20				11
12	ARCHITECT FEES			2001	3,097		20				12
13	LANDSCAPE ARCHITECT			2001	1,478		20				13
14	TOPOGRAPHIC MAPPING			2001	9,386		20				14
15	COOLER REPAIR			2000	766		20				15
16	HOT WATER SOFTNER			2001	1,150		20				16
17	FREEZER REPAIR			2001	974		20				17
18	HVAC			2001	563		20				18
19	HVAC			2001	872		20				19
20	FIRE PANEL			2001	775		20				20
21	MECHANICAL REPAIRS			2001	3,565		20				21
22	COOLER REPAIR			2001	4,121		20				22
23	WATER CHILLER			2000	49,020		20				23
24	PROFESSIONAL SERVICES - RENOVATION			2001	20,422		20				24
25	LANDSCAPE ARCHITECT			2001	11,815		20				25
26	FLOOR PAINTING			2001	499		20				26
27	STAINLESS STEEL KICK PLATE			8/21/2001	893		20				27
28	DRY WALL GUARD			10/2/2001	775		20				28
29	WINDOWS			7/19/2001	994		20				29
30	HEATING & COOLING			2002	623		20				30
31	SWING DOOR GASKETS			2002	599		20				31
32	REMOVE WORK DUCT			2002	971		20				32
33	AIR COIL			2002	951		20				33
34	RECONNECT WORK DUCT			2002	643		20				34
35	WATER MAIN REPAIR			10/12/2001	1,880		20				35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	ELECTRICAL	2002	$ 861	$	20	$	$	$	37
38	LOCK HARDWARE	2002	673		20				38
39	LOCK HARDWARE	2002	698		20				39
40	STEEL CRAFT METAL DOOR	2002	713		20				40
41	TILE	2002	1,078		20				41
42	SENTRONICS	2002	1,182		20				42
43	ASBESTOS ABATEMENT	9/30/2001	9,820		20				43
44	ARCHITECT SERVICES & ENTRY, HALL, LIBRARY	12/31/2001	155,084		20				44
45	LANDSCAPING ARCHIT	2002	11,193		20				45
46	TELEPHONE RE-WIRING	12/31/2001	2,411		20				46
47	BOILERS	2002	59,639		20				47
48	BOILERS	11/30/2001	21,400		20				48
49	BOILERS	2002	64,768		20				49
50	CONSTURCTION, ENTRY, HALL, LIBRARY	2002	1,279,284		20				50
51	BOILER REPLACEMENT	2003	169,727		10				51
52	LANDSCAPING ARCHIT	2003	26,038		10				52
53	VOICE CABLE	2003	1,137		10				53
54	PIPING	2003	91,907		10				54
55	WATER RETENTION	2003	5,071		10				55
56	AIR COMPRESSOR	2003	12,077		10				56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,186,107	$ 209,455		$ 213,039	$ 3,584	$ 13,022	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,186,107	$ 209,455		$ 213,039	$ 3,584	$ 13,022	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,186,107	$ 209,455		$ 213,039	$ 3,584	$ 13,022	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,186,107	$ 209,455		$ 213,039	$ 3,584	$ 13,022	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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17									17
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20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,186,107	$ 209,455		$ 213,039	$ 3,584	$ 13,022	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 954,517	$ 91,832	$ 91,832	$	10	$ 501,057	71
72	Current Year Purchases	300,078	13,022	13,022		10	13,022	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,254,595	$ 104,854	$ 104,854	$		$ 514,079	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	FORD E350 VAN		$ 5,030	$ 1,006	$ 1,006	$	5	$ 2,850	76
77										77
78										78
79										79
80	TOTALS			$ 5,030	$ 1,006	$ 1,006	$		$ 2,850	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,445,732	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 315,315	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 318,899	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,584	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 529,951	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-01	759 hrs	$ 16,495		$ 5,445	$	759	$ 21,940	1
2	Licensed Speech and Language Development Therapist		hrs			5,698			5,698	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-01	1078 hrs	31,252				1,078	31,252	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				399,642		399,642	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 47,747		$ 11,143	$ 399,642	1,837	$ 458,532	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION **#** 0044768 **Report Period Beginning:** 7/1/2002 **Ending:** 6/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** June 30, 2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 24,618	$	1
2	Cash-Patient Deposits	23,620		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	181,644		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,719		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): PA Pending Allowance	(42,000)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 193,601	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,049,045		13
14	Buildings, at Historical Cost	7,626,598		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,183,337		16
17	Accumulated Depreciation (book methods)	(1,464,376)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	69,720		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(18,592)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,445,732	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,639,333	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 15,737	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,033		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO OLR	17,571		36
37	DUE TO RMC	714,206		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 771,547	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 771,547	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 9,867,786	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,639,333	$	48

***(See instructions.)**

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: ###### Ending: 6/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 10,218,983	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 10,218,983	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(351,197)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (351,197)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 9,867,786	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,749,323	1
2	Discounts and Allowances for all Levels	(1,381,191)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,368,132	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	365,217	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 365,217	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	30,820	13
14	Non-Patient Meals	20,813	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	522,080	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,719	19
20	Radiology and X-Ray		20
21	Other Medical Services	102,760	21
22	Laundry	19,965	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 701,157	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(592)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (592)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplmental Schedule	1,757	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,757	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,435,671	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,463,676	31
32	Health Care	2,279,438	32
33	General Administration	1,981,358	33
	B. Capital Expense		
34	Ownership	529,951	34
	C. Ancillary Expense		
35	Special Cost Centers	458,532	35
36	Provider Participation Fee	73,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,786,868	40
41	**Income before Income Taxes (line 30 minus line 40)****	(351,197)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (351,197)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,142	$ 69,121	$ 32.27	1
2	Assistant Director of Nursing	744	928	24,876	26.81	2
3	Registered Nurses	20,566	23,095	624,034	27.02	3
4	Licensed Practical Nurses	8,805	10,027	205,750	20.52	4
5	Nurse Aides & Orderlies	72,051	79,041	985,482	12.47	5
6	Nurse Aide Trainees	2,640	2,871	62,036	21.61	6
7	Licensed Therapist	1,761	1,863	48,294	25.92	7
8	Rehab/Therapy Aides	3,599	3,814	49,139	12.88	8
9	Activity Director	1,884	2,080	35,010	16.83	9
10	Activity Assistants	8,520	9,462	99,593	10.53	10
11	Social Service Workers	1,312	1,564	23,841	15.24	11
12	Dietician					12
13	Food Service Supervisor	1,944	2,080	32,503	15.63	13
14	Head Cook	3,824	4,152	105,874	25.50	14
15	Cook Helpers/Assistants	31,524	33,989	323,515	9.52	15
16	Dishwashers					16
17	Maintenance Workers	21,447	21,695	214,664	9.89	17
18	Housekeepers	1,871	2,033	28,275	13.91	18
19	Laundry	10,460	11,187	97,160	8.69	19
20	Administrator	5,732	6,320	179,330	28.38	20
21	Assistant Administrator					21
22	Other Administrative	440	440	12,797	29.08	22
23	Office Manager					23
24	Clerical	5,244	5,624	61,717	10.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,509	1,826	24,663	13.51	31
32	Other Health Care(specify)					32
33	Other(specify) spiritual services	1,466	1,552	35,780	23.05	33
34	TOTAL (lines 1 - 33)	209,263	227,785	$ 3,343,454 *	$ 14.68	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	80	3,135		51
52	Nurse Aides	168	3,287		52
53	TOTAL (lines 50 - 52)	248	$ 6,422		53

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Judy Pitzele	Adminstrator	0	$ 95,678
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,678

B. Administrative - Other

Description	Amount
Inex-Intercompany Services	$ 506,079
TOTAL (agree to Schedule V, line 17, col. 3)	$ 506,079
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Software	$ 2,746
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,746

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,324
Unemployment Compensation Insurance	8,070
FICA Taxes	229,106
Employee Health Insurance	558,922
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Fund	127,614
Group Life	7,768
Group Disability	17,564
Other Benefits	2,719
Employee Medical	4,775
Tuition	4,490
Allocation from Resurrection HC	48,638
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,036,990

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscription	6,076
Marketing	2,485
Less: Public Relations Expense	( )
Non-allowable advertising	2,485
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,046

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,509
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,509

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: #######

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MARYHAVEN NSG & REHABILITATION # 0044768 Report Period Beginning: 7/1/2002 Ending: #

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN $4600**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **73,913**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? _____
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? _____

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.